DOCUMENT RESUME

ED 070 696 24 SO 004 803

AUTHOR	Nehnevajsa, Jiri; Brictson, Robert C.
TITLE	University-Urban Interface Program. Pittsburgh Goals: Some Thoughts on Health Issues.
INSTITUTION	Pittsburgh Univ., Pa. University Urban Interface Program.
SPONS AGENCY	Office of Education (DHEW), Washington, D.C. Bureau of Research.
BUREAU NO	BR-8-0725
PUB DATE	9 Dec 71
GRANT	OEG-2-9-480725-1027
NOTE	11p.; Paper presented at the Community-University Forum on Health Problems, University of Pittsburgh, December 9, 1971
EDRS PRICE	MF-$0.65 HC-$3.29
DESCRIPTORS	*City Problems; Community Attitudes; *Community Health Services; *Community Study; Health Services; Higher Education; Social Planning; *Social Problems; *Urban Universities
IDENTIFIERS	Pittsburgh

ABSTRACT

Comments from community leaders in Pittsburgh concerning health issues point out some of the major examples of the kinds of concerns and suggestions for action voiced in the University-Urban Interface Program study on Pittsburgh goals. Quotations from the questionnaire administered by the goals committee also illustrate the kinds of things which Pittsburgh leaders believe should not be done in this area. Statistical tables summarize information concerning the desirability, likelihood, and importance of innovations in the distribution and accessibility of health care studies and new developments regarding the payment for health care services. The premise is stated that this study of opinions of community leaders in Pittsburgh provides information which can contribute to improved community response, thought, decision, and action in the area of health problems. See SO 004 802 for related documents. (SHM)

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CONTRACT NO. OEG-2-9-480725-1027
PROJECT NO. 80725

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OFFICE OF THE SECRETARY
UNIVERSITY OF PITTSBURGH

DECEMBER 9, 1971

SO 004 823

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UNIVERSITY-URBAN INTERFACE PROGRAM

PITTSBURGH GOALS: SOME THOUGHTS ON HEALTH ISSUES

DECEMBER 9, 1971

by

Jiri Nehnevajsa

and

Robert C. Brictson

This paper presented at the Community-University Forum on Health Problems, University of Pittsburgh, December 9, 1971.

Albert C. Van Dusen, Ph.D.
Secretary of the University
Principal Investigator

Robert C. Brictson, Ph.D.
Director of Research Programs

Ladies and Gentlemen,

> It is time that the state, Federal, and local governments stop talking about what they are going to do about "health care" services and <u>begin</u> doing something.

This is a verbatim quotation from a community leader who is involved in the Pittsburgh Anti-Poverty efforts. An industrial leader,when asked to identify the kinds of things that should be done in the area of health care, both from the vantage point of delivery systems and payment for services, says the following:

> Stronger, unified, broad community planning based on factual determination of need. A broader view of the entire community by providers of health care.

Still another leader comments in this manner:

> Citizens should be made aware of, and informed about, the health care services available. Detoxification, Drug Abuse, Mental Health, Job Placement, and Training Centers should be established and made available to all citizens who need such services. Too, relief should be given to the poor and needy and the aged people with fixed and limited incomes so that they can get medical and other health care services they need.

A leader in Pittsburgh's Black Community Programs so states the issue:

> There should be identified a feasible geographic community within the various neighborhoods which would serve as a base for the organization of required services for the community. Key persons within the area should become members of a nonprofit corporation and then operating committees should be formed to address themselves to all aspects of service needs for the community.

An educational leader makes the following more concrete recommendations:

> (a) Expansion of ambulatory care facilities for acute and chronic illness.
>
> (b) Development of extended care facilities, nursing homes, etc. on a <u>not-for-profit</u> operation basis.
>
> (c) Development of alternate forms of health care delivery system through health maintenance organizations, group practice

capitation experiments, neighborhood clinics, home care programs, and so on.

(d) Development of fully integrated facilities and services planning system with predetermination of total community needs.

Another community leader, one associated with Health and Welfare services, suggests that

> Health care services for the "poor" or "needy" have to be changed. Recipients (welfare and social security) should receive enough monies in their grant to cover visits to doctors offices. And have some type of medical plan for hospital stay.

These are only some of the major examples of the kinds of concerns and suggestions for action which Pittsburgh leaders have voiced in our study of Pittsburgh Goals. Let us also illustrate the types of things which the leaders feel ought <u>not</u> to be done. The first quotation comes from a leader in Housing and Urban Development:

> Health care facilities should not be forced into affluent suburbs but should be encouraged to remain in the city with financial aid provided by all governmental levels.
>
> Health care facilities should be available to all persons and no one should be turned away for lack of funds.

One of the leaders in Religious Social Service Program advocates concurrently, the elimination of duplication, improvement in the quality of services and reduction of costs. However, he also advises that efforts at eliminating duplication of services should not be started "until a comprehensive plan is completed and methods of implementing it are clear."

A leader in Health and Welfare so specifies some of his cautions:

(a) Should not allow continued uncontrolled growth of individual facilities and services without regard to total community needs determined by a master plan.

(b) Should not promise or accept complete government

control of health care services and facilities.

(c) Should not enact any massive national health care Program until and/or unless adequate facilities, services, and personnel are available to render needed service.

Such individual kinds of comments, illustrative as they are, perhaps become more meaningful when in summary form.

1. There is obvious clamor for community-wide planning in the area of health services.

2. There is a deep-seated issue which has to do with health programs of the nonprofit versus profit variety, and there is strong preference for the development of nonprofit programs and their incorporation into the overall health system.

3. There is a great deal of feeling in favor of efforts which would not duplicate the expensive medical facilities already available, an issue which is, in part, connected with the desire for overall community planning.

4. There is a great deal of agreement that the services for the "needy", in terms of their ability to pay, must be expanded, and that we cannot afford discrimination in medical services in terms of ability to pay.

5. There is endorsement for such things as neighborhood clinics, and generally, specialized programs which provide all the neighborhood services needed. The community leaders see the Hospital Planning Association as advocating the kinds of reforms which are needed and desired. And they tend to see many individual physicians, and the American Medical Association as among the opponents of such reforms. Such views appear to endorse development of more cooperative, collaborative

efforts at master plans among associations,facilities, specialists, and institutions, whereas they oppose expansion based solely on proprietary, completely autonomous interests.

The 106 Pittsburgh leaders who chose to answer our questionnaire have some other things to say, things which can be expressed in a more quantitative manner. The problem of delivery of medical services is seen as more salient than the problem of payment. (Please, refer to Tables 1. and 2.) Although these leaders consider the delivery system among the most important issues, they relegate the issue of payment for health services to a lesser role. The delivery system problem ranks among the most important community issues. The "payment problem" is also crucial, but somewhat less so than the delivery issue.

If there are generalizations to be made, they are of the following character:

(a) Improvements in delivery systems of health care are quite desirable, and in each group of leaders, they rank among the top 10 of desirable Pittsburgh changes.

(b) The leaders also think that some desirable changes are fairly likely in the coming five years. Changes in payment systems for medical services are much more likely than improvements in delivery patterns. At the same time, leaders rate likelihood of change in payment-related programs higher than either the importance or the desirability of such action. This clearly shows a conflict in priorities.

(c) Leaders in mass media, education, health and welfare, and black community programs consider "delivery systems" reforms among the most

Table 1.

DESIRABILITY" LIKELIHOOD, AND IMPORTANCE OF "INNOVATIONS IN THE DISTRIBUTION AND ACCESSIBILITY OF HEALTH CARE SERVICES " (PITTSBURGH LEADERS)

	Desirability		Likelihood		Importance	
	Average	Rank	Average	Rank	Average	Rank
All (106) leaders	+ 1.51	5	6.70	7	8.24	5
Government and Law	+ 1.47	8.5	6.70	7	8.00	7
Business and Banking	+ 1.38	7.5	7.23	6.5	7.77	7
Education	+ 1.45	3	7.33	6	8.45	3
Health and Welfare	+ 1.82	2.5	7.18	7.5	8.91	5
Housing and Urban Development	+ 1.28	10	4.28	15.5	7.43	10.5
Black Community Programs	+ 1.50	4.5	6.00	9	8.17	2.5
Anti-Poverty Programs	+ 1.54	6	7.73	2.5	8.50	6
Religious Social Services	+ 1.50	10	6.58	9	8.08	9.5
Environment Control	+ 1.75	4.5	8.00	5	9.25	2
Media	+ 1.70	2	6.50	10.5	8.50	1.5

For explanation of the Table, see footnote to Table 2.

Table 2.

DESIRABILITY, LIKELIHOOD AND IMPORTANCE OF "NEW DEVELOPMENTS REGARDING THE PAYMENT FOR HEALTH-CARE SERVICES" (PITTSBURGH LEADERS)

	Desirability		Likelihood		Importance	
	Average	Rank	Average	Rank	Average	Rank
All (106) leaders	+ 1.28	12	6.88	5	7.66	13
Government and Law	+ 1.20	12	6.67	4	7.33	12
Business and Banking	+ 1.00	15.5	6.69	10	6.46	19
Education	+ 1.20	13	7.56	3	7.90	11
Health and Welfare	+ 1.54	11.5	7.73	4	8.64	9
Housing and Urban Development	+ 1.14	13.5	5.43	7.5	7.43	10.5
Black Community Programs	+ 1.17	10	6.80	5	7.00	13
Anti-Poverty Programs	+ 1.45	8.5	6.73	7	7.70	14
Religious Social Services	+ 1.25	13.5	6.25	12.5	7.75	13
Environment Control	+ 1.75	4.5	7.75	6	9.25	2
Media	+ 1.50	8.5	7.50	4.5	8.10	5

Desirability scale goes from (-2) to (+2) as minimum and maximum respectively.
Likelihood scale goes from (0) to (10).
Importance scale admits of values from (0) to (10).
Ranks reported here reflect the ranking of each item, for the group cited, among the 28 alternatives explicitly cited in the questionnaires.
When rankings are tied (that is, two or more items have the same "value" on desirability, or likelihood, or importance), the average for such tied ranks is given.

desirable changes in Pittsburgh in the coming years.

(d) Leaders in Anti-Poverty Programs and in Religious Social Services also consider such programs very likely.

(e) All groups of leaders view reforms as quite important, although leaders in Housing and Urban Development consider them relatively less important than do the other community leaders.

(f) Changes in patterns of payments for health services are considered likely by all groups of the community leaders. The leaders of Religious Social Service Programs are least optimistic in this regard.

We could indeed, go on. Suffice it to say that we have tried to go a little beyond the brief summary of the Pittsburgh Goals study which you all have received prior to coming here. All in all, 106 community leaders representing various constituencies responded to our questionnaires. They include leaders from the following categories: government and the law, business and banking, education, health, and welfare, urban and housing development, black community programs, anti-poverty efforts, environment control, mass media, religious social service programs, and others, especially leaders of various ethnic groups in the community.

The leaders who cooperate in the study display a great deal of concern with, and interest in, community problems.

They agree on the basic things that need doing, although they do not agree on how we might go about getting these things done.

They also generally agree that the political parties, the politicians, and "politics as usual" are among the major impediments.

They also agree that there are grounds for some pessimism regarding

the future of our area, in that the more desirable futures are somewhat unlikely; that the outmigration is likely to continue and that our area might continue to stagnate, or even to deteriate.

They also agree that leadership is needed. They agree that such leadership must be complementary to the political system, and that it calls for personalities of the inspirational and catalytic varieties typified by Richard King Mellon.

To make sure that these remarks are not misunderstood, let me repeat a few more points.

First, there is no pretension that the study is representative of Pittsburgh leadership. The responses include 106 prominent leaders of the community, but this does in no way mean that their attitudes in any way represent the entire community, or even all the possible community leaders. Just to give an example: only 17 per cent of labor leaders, and only 25 per cent of black community program leaders shared their insights with us. Among the leaders of white ethnic groups, the percentages are even smaller. Conversely, more than eighty per cent of the mass media leaders participated as respondents. But because some leaders in the community chose not to respond at this time does not alter the basic results which we do not try to claim to be representative. The results provide us with important <u>insights</u>, and representativeness is then only a secondary issue.

Secondly, we do not assume that the leaders who did respond were somehow speaking on behalf of the organizations and agencies in which they function. Indeed, we took their responses as <u>individual</u> expressions. Our results are not in any way geared to interpreting what significant

organizations or agencies in the community might be saying.

Thirdly, we have no idea at this time as to the extent to which the views if the leaders do, or do not, reflect the sentiments of the larger Pittsburgh community. Thus we do not pretend to know what the different groups of the community population consider important, desirable, or likely. Yet, on balance, we have learned a lot.

Finally, based on these experimental Community-University Forums we hope to be able to articulate another facet of community opinion--one that taps the expertise of groups selected and invited by their colleagues and peers to participate in discussion of a specific issue related to their training and experience.

Neither you or I want to be victims of some implacable destiny. We want to help make our future. We want to be in a position to affect our destiny. Study, analysis, and discussion facilitate such efforts.

This study of Pittsburgh leaders does not solve the basic problem, nor does it recommend specific courses of action. But it may provide an additional input, a piece of information, which can contribute to improved community response, deliberation, decision, and action, in the critical area of health problems. Hopefully, some important additional inputs and directions may result from your work today.